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HOMELAND SECURITY

New Department Could Improve Coordination but May Complicate Public Health Priority Setting

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Mr. Chairman and Members of the Committee:

I appreciate the opportunity to be here today to discuss the proposed creation of the Department of Homeland Security. Since the terrorist attacks of September 11, 2001, and the subsequent anthrax incidents, there has been concern about the ability of the federal government to prepare for and coordinate an effective public health response to such events, given the broad distribution of responsibility for that task at the federal level. Our earlier work found, for example, that more than 20 federal departments and agencies carry some responsibility for bioterrorism preparedness and response and that these efforts are fragmented.¹ Emergency response is further complicated by the need to coordinate actions with agencies at the state and local level, where much of the response activity would occur.

The President's proposed Homeland Security Act of 2002 would bring many of these federal entities with homeland security responsibilities—including public health preparedness and response—into one department, in an effort to mobilize and focus assets and resources at all levels of government. The aspects of the proposal concerned with public health preparedness and response would involve two primary changes to the current system, which are found in Title V of the proposed bill. First, the proposal would transfer certain emergency preparedness and response programs from multiple agencies to the new department. Second, it would transfer the control over, but not the operation of, other public health preparedness assistance programs, such as providing emergency preparedness planning assistance to state and local governments, from the Department of Health and Human Services (HHS) to the new department.²

In order to assist the committee in its consideration of this extensive reorganization of our government, my remarks today will focus on Title V of the President's proposal and the implications of (1) the proposed transfer of specific public health preparedness and response programs currently housed in HHS into the new department and (2) the proposed transfer of control over certain other public health preparedness assistance programs from HHS to the new department. My testimony

¹U.S. General Accounting Office, *Bioterrorism: Federal Research and Preparedness Activities*, [GAO-01-915](#), (Washington, D.C.: Sept. 28, 2001).

²These changes are primarily covered by Sections 502 and 505, respectively, in Title V of the President's proposed legislation.

today is based largely on our previous and ongoing work on federal, state, and local preparedness in responding to bioterrorist threats,³ as well as a review of the proposed legislation.

In summary, we believe that the proposed reorganization has the potential to repair the fragmentation we have noted in the coordination of public health preparedness and response programs at the federal, state, and local levels. As we have recommended, the proposal would institutionalize the responsibility for homeland security in federal statute. We expect that, in addition to improving overall coordination, the transfer of programs from multiple agencies to the new department could reduce overlap among programs and facilitate response in times of disaster. However, we have concerns about the proposed transfer of control from HHS to the new department for public health assistance programs that have both basic public health and homeland security functions. These dual-purpose programs have important synergies that we believe should be maintained. We are concerned that transferring control over these programs, including priority setting, to the new department has the potential to disrupt some programs that are critical to basic public health responsibilities. We do not believe that the President's proposal is sufficiently clear on how both the homeland security and the public health objectives would be accomplished.

Background

Federal, state, and local government agencies have differing roles with regard to public health emergency preparedness and response. The federal government conducts a variety of activities, including developing interagency response plans, increasing state and local response capabilities, developing and deploying federal response teams, increasing the availability of medical treatments, participating in and sponsoring exercises, planning for victim aid, and providing support in times of disaster and during special events such as the Olympic games. One of its main functions is to provide support for the primary responders at the state and local level, including emergency medical service personnel, public health officials, doctors, and nurses. This support is critical because the burden of response falls initially on state and local emergency response agencies.

³See "Related GAO Products" at the end of this testimony.

The President's proposal transfers control over many of the programs that provide preparedness and response support for the state and local governments to a new Department of Homeland Security. Among other changes, the proposed bill transfers HHS's Office of the Assistant Secretary for Public Health Emergency Preparedness to the new department. Included in this transfer is the Office of Emergency Preparedness (OEP), which currently leads the National Disaster Medical System (NDMS)⁴ in conjunction with several other agencies and the Metropolitan Medical Response System (MMRS).⁵ The Strategic National Stockpile,⁶ currently administered by the Centers for Disease Control and Prevention (CDC), would also be transferred, although the Secretary of Health and Human Services would still manage the stockpile and continue to determine its contents.

Under the President's proposal, the new department would also be responsible for all current HHS public health emergency preparedness activities carried out to assist state and local governments or private organizations to plan, prepare for, prevent, identify, and respond to biological, chemical, radiological, and nuclear events and public health emergencies. Although not specifically named in the proposal, this would include CDC's Bioterrorism Preparedness and Response program and the Health Resources and Services Administration's (HRSA) Bioterrorism Hospital Preparedness Program. These programs provide grants to states and cities to develop plans and build capacity for communication, disease surveillance, epidemiology, hospital planning, laboratory analysis, and other basic public health functions. Except as directed by the President, the Secretary of Homeland Security would carry out these activities through HHS under agreements to be negotiated with the Secretary of

⁴In the event of an emergency, the National Disaster Medical System has response teams that can provide support at the site of a disaster. These include specialized teams for burn victims, mental health teams, teams for incidents involving weapons of mass destruction, and mortuary teams that can be deployed as needed. About 2,000 civilian hospitals have pledged resources that could be marshaled in any domestic emergency under the system.

⁵The Metropolitan Medical Response System is a program that provides support for local community planning and response capabilities for mass casualty and terrorist incidents in metropolitan areas.

⁶The stockpile, previously called the National Pharmaceutical Stockpile, consists of two major components. The first component is the 12-Hour Push Packages, which contain pharmaceuticals, antidotes, and medical supplies and can be delivered to any site in the United States within 12 hours of a federal decision to deploy assets. The second component is the Vendor Managed Inventory.

HHS. Further, the Secretary of Homeland Security would be authorized to set the priorities for these preparedness and response activities.

Reorganization Has Potential to Improve Coordination

The consolidation of federal assets and resources in the President's proposed legislation has the potential to improve coordination of public health preparedness and response activities at the federal, state, and local levels. Our past work has detailed a lack of coordination in the programs that house these activities, which are currently dispersed across numerous federal agencies. In addition, we have discussed the need for an institutionalized responsibility for homeland security in federal statute.⁷ The proposal provides the potential to consolidate programs, thereby reducing the number of points of contact with which state and local officials have to contend, but coordination would still be required with multiple agencies across departments. Many of the agencies involved in these programs have differing perspectives and priorities, and the proposal does not sufficiently clarify the lines of authority of different parties in the event of an emergency, such as between the Federal Bureau of Investigation (FBI) and public health officials investigating a suspected bioterrorist incident. Let me provide you more details.

We have reported that many state and local officials have expressed concerns about the coordination of federal public health preparedness and response efforts.⁸ Officials from state public health agencies and state emergency management agencies have told us that federal programs for improving state and local preparedness are not carefully coordinated or well organized. For example, federal programs managed by the Federal Emergency Management Agency (FEMA), Department of Justice (DOJ), and OEP and CDC all currently provide funds to assist state and local governments. Each program conditions the receipt of funds on the completion of a plan, but officials have told us that the preparation of multiple, generally overlapping plans can be an inefficient process.⁹ In addition, state and local officials told us that having so many federal entities involved in preparedness and response has led to confusion,

⁷U.S. General Accounting Office, *Homeland Security: Responsibility and Accountability for Achieving National Goals*, [GAO-02-627T](#) (Washington, D.C.: Apr. 11, 2002).

⁸U.S. General Accounting Office, *Bioterrorism: Federal Research and Preparedness Activities*, [GAO-01-915](#), (Washington, D.C.: Sept. 28, 2001).

⁹U.S. General Accounting Office, *Combating Terrorism: Intergovernmental Partnership in a National Strategy to Enhance State and Local Preparedness*, [GAO-02-547T](#) (Washington, D.C.: Mar. 22, 2002).

making it difficult for them to identify available federal preparedness resources and effectively partner with the federal government.

The proposed transfer of numerous federal response teams and assets to the new department would enhance efficiency and accountability for these activities. This would involve a number of separate federal programs for emergency preparedness and response, including FEMA; certain units of DOJ; and HHS's Office of the Assistant Secretary for Public Health Emergency Preparedness, including OEP and its NDMS and MMRS programs, along with the Strategic National Stockpile. In our previous work, we found that in spite of numerous efforts to improve coordination of the separate federal programs, problems remained, and we recommended consolidating the FEMA and DOJ programs to improve the coordination.¹⁰ The proposal places these programs under the control of one person, the Under Secretary for Emergency Preparedness and Response, who could potentially reduce overlap and improve coordination. This change would make one individual accountable for these programs and would provide a central source for federal assistance.

The proposed transfer of MMRS, a collection of local response systems funded by HHS in metropolitan areas, has the potential to enhance its communication and coordination. Officials from one state told us that their state has MMRSs in multiple cities but there is no mechanism in place to allow communication and coordination among them. Although the proposed department has the potential to facilitate the coordination of this program, this example highlights the need for greater regional coordination, an issue on which the proposal is silent.

Because the new department would not include all agencies having public health responsibilities related to homeland security, coordination across departments would still be required for some programs. For example, NDMS functions as a partnership among HHS, the Department of Defense (DOD), the Department of Veterans Affairs (VA), FEMA, state and local governments, and the private sector. However, as the DOD and VA programs are not included in the proposal, only some of these federal organizations would be brought under the umbrella of the Department of Homeland Security. Similarly, the Strategic National Stockpile currently involves multiple agencies. It is administered by CDC, which contracts

¹⁰U.S. General Accounting Office, *Combating Terrorism: Selected Challenges and Related Recommendations*, [GAO-01-822](#) (Washington, D.C., Sept. 20, 2001).

with VA to purchase and store pharmaceutical and medical supplies that could be used in the event of a terrorist incident. Recently expanded and reorganized, the program will now include management of the nation's inventory of smallpox vaccine. Under the President's proposal, CDC's responsibilities for the stockpile would be transferred to the new department, but VA and HHS involvement would be retained, including continuing review by experts of the contents of the stockpile to ensure that emerging threats, advanced technologies, and new countermeasures are adequately considered.

Although the proposed department has the potential to improve emergency response functions, its success is contingent on several factors. In addition to facilitating coordination and maintaining key relationships with other departments, these include merging the perspectives of the various programs that would be integrated under the proposal, and clarifying the lines of authority of different parties in the event of an emergency. As an example, in the recent anthrax events, local officials complained about differing priorities between the FBI and the public health officials in handling suspicious specimens. According to the public health officials, FBI officials insisted on first informing FBI managers of any test results, which delayed getting test results to treating physicians. The public health officials viewed contacting physicians as the first priority in order to ensure that effective treatment could begin as quickly as possible.

New Department's Control of Essential Public Health Capacities Raises Concern

The President's proposal to shift the responsibility for all programs assisting state and local agencies in public health emergency preparedness and response from HHS to the new department raises concern because of the dual-purpose nature of these activities. These programs include essential public health functions that, while important for homeland security, are critical to basic public health core capacities.¹¹ Therefore, we are concerned about the transfer of control over the programs, including priority setting, that the proposal would give to the new department. We recognize the need for coordination of these activities with other

¹¹The recently enacted Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L.107-188) cited core public health capacities that state and local governments need, including effective public health surveillance and reporting mechanisms, appropriate laboratory capacity, properly trained and equipped public health and medical personnel, and communications networks that can effectively disseminate relevant information in a timely and secure manner.

homeland security functions, but the President's proposal is not clear on how the public health and homeland security objectives would be balanced.

Under the President's proposal, responsibility for programs with dual homeland security and public health purposes would be transferred to the new department. These include such current HHS assistance programs as CDC's Bioterrorism Preparedness and Response program and HRSA's Bioterrorism Hospital Preparedness Program. Functions funded through these programs are central to investigations of naturally occurring infectious disease outbreaks and to regular public health communications, as well as to identifying and responding to a bioterrorist event. For example, CDC has used funds from these programs to help state and local health agencies build an electronic infrastructure for public health communications to improve the collection and transmission of information related to both bioterrorist incidents and other public health events.¹² Just as with the West Nile virus outbreak in New York City, which initially was feared to be the result of bioterrorism,¹³ when an unusual case of disease occurs public health officials must investigate to determine whether it is naturally occurring or intentionally caused. Although the origin of the disease may not be clear at the outset, the same public health resources are needed to investigate, regardless of the source.

States are planning to use funds from these assistance programs to build the dual-purpose public health infrastructure and core capacities that the recently enacted Public Health Security and Bioterrorism Preparedness and Response Act of 2002¹⁴ stated are needed. States plan to expand laboratory capacity, enhance their ability to conduct infectious disease surveillance and epidemiological investigations, improve communication among public health agencies, and develop plans for communicating with the public. States also plan to use these funds to hire and train additional staff in many of these areas, including epidemiology.

¹²These include the Health Alert Network (HAN), a nationwide system that facilitates the distribution of health alerts, dissemination of prevention guidelines and other information, distance learning, national disease surveillance, and electronic laboratory reporting, and Epi-X, a secure Web-based disease surveillance network for federal, state, and local epidemiologists that provides tools for searching, tracking, discussing, and reporting on diseases and is therefore a key element in any disease investigation.

¹³U.S. General Accounting Office, *West Nile Virus Outbreak: Lessons for Public Health Preparedness*, [GAO/HEHS-00-180](#) (Washington, D.C.: Sept. 11, 2000).

¹⁴P.L. 107-188.

Our concern regarding these dual-purpose programs relates to the structure provided for in the President's proposal. The Secretary of Homeland Security would be given control over programs to be carried out by another department. The proposal also authorizes the President to direct that these programs no longer be carried out in this manner, without addressing the circumstances under which such authority would be exercised. We are concerned that this approach may disrupt the synergy that exists in these dual-purpose programs. We are also concerned that the separation of control over the programs from their operations could lead to difficulty in balancing priorities. Although the HHS programs are important for homeland security, they are just as important to the day-to-day needs of public health agencies and hospitals, such as reporting on disease outbreaks and providing alerts to the medical community. The current proposal does not clearly provide a structure that ensures that both the goals of homeland security and public health will be met.

Concluding Observations

Many aspects of the proposed consolidation of response activities are in line with our previous recommendations to consolidate programs, coordinate functions, and provide a statutory basis for leadership of homeland security. The transfer of the HHS medical response programs has the potential to reduce overlap among programs and facilitate response in times of disaster. However, we are concerned that the proposal does not provide the clear delineation of roles and responsibilities that we have stated is needed. We are also concerned about the broad control the proposal grants to the new department for public health preparedness programs. Although there is a need to coordinate these activities with the other homeland security preparedness and response programs that would be brought into the new department, there is also a need to maintain the priorities for basic public health capacities that are currently funded through these dual-purpose programs. We do not believe that the President's proposal adequately addresses how to accomplish both objectives.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other Members of the Committee may have at this time.

Contact and Acknowledgments

For further information about this testimony, please contact me at (202) 512-7118. Marcia Crosse, Greg Ferrante, Deborah Miller, and Roseanne Price also made key contributions to this statement.

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